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John M. Miller

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NATIONAL LABOR RELATIONS ACT—HISTORY AND INTERPRETATION OF THE HEALTH CARE AMENDMENTS

I. INTRODUCTION

On July 26, 1974, the President signed Public Law 93-360, enacting the health care amendments to the National Labor Relations Act (hereinafter called the Act). These amendments, which extend the coverage of the Labor Management Relations Act to employees of nonprofit health care facilities, reveal a growing concern in the legislature for the labor relations problems which have plagued the health care industry.

Prior to the enactment of the health care amendments,¹ state laws regulated the health care industry. As a result, multi-state employers were faced with substantial inconsistencies in the law, making compliance a difficult and expensive task. On the other hand, the protection afforded the three million industry employees² throughout the country varied, depending on the state in which they were employed. Furthermore, organizational activity caused serious disruptions of health care services, while the wages earned by nonprofit hospital workers were substantially lower than those earned by other employees in the health care field.³

Congress recognized the need for legislative action to provide a stable and consistent national labor policy for the health care industry.⁴ Throughout deliberations on the amendments, Congress emphasized this need for strong and comprehensive federal action. Since the enactment of the amendments the courts have also emphasized their stabilizing purpose by strong statements to the National Labor Relations Board that it must enforce the new federal policy even if it must do so by disregarding and, where necessary, overruling state laws.⁵ This article describes the legislative changes made by the health care

1. The effective date of the new legislation amending the Labor Management Relations Act, 29 U.S.C. §§ 150 *et seq.* was August 25, 1974.

2. FEDERAL MEDIATION AND CONCILIATION SERVICE, TWENTY-EIGHTH ANNUAL REPORT (FISCAL YEAR 1975), ch. IV, at 25.

3. See 120 CONG. REC. 12937 (1974). See also Feheley, *Amendments to the National Labor Relations Act: Health Care Institutions*, 36 OHIO ST. L.J. 235 (1975).

4. See, e.g., 120 CONG. REC. 12934 (1974) (remarks of Senator Cranston); see also 120 CONG. REC. 16899 (1974) (remarks of Senator Thompson).

5. See *Memorial Hosp. v. NLRB*, ___ F.2d ___, 93 LRRM 2571 (3rd Cir. 1976).

amendments and analyzes how the NLRB has applied them to date, especially in light of the duty imposed by the amendments on the NLRB to assert itself in this new and uncharted area of labor law.

II. POLICY OF THE AMENDMENTS

The amendments have a dual purpose which must be kept constantly in mind for a clear understanding of how the NLRB has applied the new legislation. One of the purposes was to extend the coverage of the Act to employees in the nonprofit health care industry. The other purpose was to prevent undue disruptions of health care services, especially vital life saving services.⁶

In a public sector labor dispute the public interest, not relative economic strength of the parties to the dispute, is often the controlling factor. The health care amendments represent the first time that the public interest is a determinative factor in the resolution of a private-sector labor dispute. Up to now a private-sector dispute was resolved solely by the relative economic strength of the parties. But in some instances the amendments restrict both management and labor groups from engaging in activity otherwise permissible in private-sector disputes in order to protect the public's right to receive necessary medical services. Thus far in its handling of disputes in the health care industry, the NLRB has tended to tip the balance in favor of preserving health care services, often at the expense of denying employees the full benefits of the Act.

III. DEFINITION OF HEALTH CARE INSTITUTIONS

The most basic change in the Act made by the health care amendments is simply to repeal the exemption for nonprofit hospitals found in section 2(2) of the Act.⁷ Now the benefits and burdens imposed by the Act are extended to employers in the

6. For the legislative history, see 120 CONG. REC. 12943 (1974); 120 CONG. REC. 16900 (1974).

7. 29 U.S.C. § 152(2) (1970) amended reads:

The term "employer" includes any person acting as an agent of an employer, directly or indirectly, but shall not include the United States or any wholly owned Government corporation, or any Federal Reserve Bank, or any State or political subdivision thereof, or any person subject to the Railway Labor Act, as amended from time to time, or any labor organization (other than when acting as an employer), or anyone acting in the capacity of officer or agent of such labor organization.

nonprofit health care field and employees working within these institutions.⁸

The amendments also added a comprehensive definition of "health care institution" to section 2. That section now states:

The term "health care institution" shall include any hospital, health maintenance organization, health clinic, nursing home, extended care facility, or other institution devoted to the care of sick, infirm, or aged persons.

The legislative history makes clear that government operated health care institutions are still exempt from the Act.⁹ The NLRB has complied with this legislative mandate and has not extended its jurisdiction over health facilities run by political subdivisions. However, the NLRB has made an important distinction between actual administrative control and mere financial support of health care institutions. The NLRB has exerted jurisdiction over institutions funded by governmental sources even though such funding was virtually the facility's sole means of financial support.¹⁰ Only when the political subdivision exerts actual control over the administration and physical operation of the facility has jurisdiction been denied.¹¹

A second change made by the legislation provides for coverage of the Act for all religiously affiliated health care institutions. This extension of coverage resulted when an amendment proposed by Senator Ervin which would have specifically exempted such religious institutions from coverage was defeated.¹²

Aside from the conclusions which can be drawn from the legislative history, Congress provided very little guidance regarding which institutions are covered by the Act. The legislators indicated that health-related facilities such as health spas, diet clinics and body building centers are not covered under the

8. Prior to the amendments § 2(2), the Act specifically excluded "any corporation or association operating a hospital, if no part of the net earnings inures to the benefit of any private shareholder or individual"

9. S. REP. NO. 93-766, 93d Cong., 2d Sess. 4 (1974); 120 CONG. REC. 6397 (1974); 120 CONG. REC. 12935 (1974).

10. See, e.g., *Morristown-Hamblen Hosp. Ass'n*, 226 N.L.R.B. No. 13, 93 LRRM 1166 (Sept. 22, 1976); *Mental Health Center*, 222 N.L.R.B. No. 146, 91 LRRM 1326 (Feb. 13, 1976); *Malcolm X Center*, 222 N.L.R.B. No. 147, 91 LRRM 1352 (Feb. 19, 1976).

11. See, e.g., the Board's discussion in *Rouse Home*, 225 N.L.R.B. No. 125, 93 LRRM 1013 (Sept. 22, 1976).

12. 120 CONG. REC. 12946 (1976). The amendment was offered by Senator Ervin.

new amendments,¹³ but they clearly intended to cover specialty care centers such as private homes for the mentally retarded.¹⁴ But the examples given by the legislators hardly cover the wide variety of facilities which actually exist. In the face of this lack of direction from Congress, the NLRB has established a standard based upon the entire legislative history of the amendments. The test developed by the NLRB is based on whether the facility provides direct patient care or whether it merely provides indirect health maintenance. In applying this standard, the Board has applied the amendments to a rehabilitation center for retarded persons¹⁵ and a center for the care of children with behavioral problems.¹⁶ However, in *San Diego Blood Bank*¹⁷ the NLRB refused to apply the amendments to a blood bank set up to supply area hospitals with fresh blood. Apparently, the NLRB requires an institution covered by the Act to provide direct patient care within its facilities, including actual treatment of the medical ailment, either mental or physical. By developing this standard, the NLRB can now more readily deal with the large variety of facilities, each with its own character and function.

IV. JURISDICTIONAL STANDARDS

During the Senate's consideration of the amendments, the jurisdictional standards which must be met before federal law can be applied to any health care institution provided fertile ground for debate. Senator Taft, for example, called for the maintenance of, or even an increase, in the preamendment monetary standards used to determine when a health care institution was involved in interstate commerce.¹⁸ Opposing this view, Senator Williams called for a substantial decrease in the jurisdictional amount.¹⁹

13. GENERAL COUNSEL MEMORANDUM 74-49, at 3 (August 20, 1974).

14. 120 CONG. REC. 16900 (1974); 120 CONG. REC. 12935 (1974).

15. See *Chicago School & Workshop*, 225 N.L.R.B. No. 172, 93 LRRM 1052 (Sept. 8, 1976); *Mental Health Services*, 220 N.L.R.B. No. 18, 90 LRRM 1394 (Sept. 3, 1975).

16. *St. Aloysius Home*, 224 N.L.R.B. No. 70, 92 LRRM 1355 (June 21, 1976); *Trailback, Inc.*, 221 N.L.R.B. No. 107, 91 LRRM 1037 (Nov. 19, 1975) (drug related problems).

17. 219 N.L.R.B. 116 (1975); see also *Dane County Chapter*, 224 N.L.R.B. No. 30, 92 LRRM 1234 (June 2, 1976).

18. See GENERAL COUNSEL MEMORANDUM, *supra* note 13, 304, citing Senator Taft's remarks during Senate debate.

19. 120 CONG. REC. 12104 (1974).

Prior to the amendments the jurisdictional amount was set at \$250,000 of gross annual income for hospitals²⁰ and \$100,000 of gross annual income for nursing homes.²¹ In an attempt to attain stability in the area of labor relations, the NLRB has refused to take either side of the dispute found in the Committee Reports and has retained the prior standards.²² Because the Act has expanded the pre-amendment definition of health care institution, the NLRB has also established a \$250,000 standard for specialty clinics and hospitals.²³ This standard is consistent with the intent of the Act. The facilities which would have been most adversely affected by lowering the jurisdictional amount are small medical clinics with less than ten employees. The decrease would have entailed constitutional questions concerning the authority of the federal government to interfere with local industry and would have subjected small facilities to a great potential for disruptions of health care services. To encourage this disruptive result by lowering the monetary standards would have directly contravened the stabilizing policy of the amendments.

V. NOTICE

The most substantial changes in the Act effected by the health care amendments are the notice requirements of section 8. This section requires a labor organization to give an employer written notice of its intention to picket, strike or otherwise refuse to work. These notice requirements are a direct extension of the legislative intent to prevent undue disruption of health care services during a labor dispute. During the notice period the employer has a chance to prepare for disruptions, including work stoppages, and the labor organization is prohibited from acting.

Section 8(g) of the Act²⁴ requires a labor organization to give

20. *See Butte Medical Properties*, 168 N.L.R.B. 266 (1967).

21. *See University Nursing Home, Inc.*, 168 N.L.R.B. 263 (1967).

22. *See East Oakland Community Health Alliance, Inc.*, 218 N.L.R.B. 1270 (1975).

23. *Id.*

24. Sec. 8(g) of the Act reads:

A labor organization before engaging in any strike, picketing, or other concerted refusal to work at any health care institution shall, not less than ten days prior to such action, notify the institution in writing and the Federal Mediation and Conciliation Service of that intention, except that in the case of bargaining for an initial agreement following certification or recognition the notice required by this subsection shall not be given until the expiration of the period specified

the employer and the Federal Mediation and Conciliation Service (FMCS) ten-day written notice²⁵ of its intentions before engaging in "any strike, picketing, or other concerted refusal to work." The Senate and House reports, however, suggest that more than mere compliance with section 8(g) is necessary to constitute proper notice:

[I]t would be unreasonable, in the Committee's judgment, if a strike or picketing commenced more than 72 hours after the time specified in the notice. In addition, since the purpose of the notice is to give health care institutions advance notice of the actual commencement of a strike or picketing, if a labor organization does not strike at the time specified in the notice, at least 12 hours notice should be given of the actual time for commencement of the action.²⁶

Stated more simply, a labor organization is required to give a ten-day notice to both the employer and the FMCS of any strike or picketing activity in which it plans to engage. If at the end of that period the activity does not take place, the labor organization is given an additional seventy-two hours in which to commence the action. Furthermore, if the activity is to begin within the seventy-two hour grace period, a second twelve hour notice of the exact time of the commencement must be given. If the union completely fails to act within the grace period, it must give a new ten-day notice, before further activity is legal. This notice procedure gives a clear indication of the Congressional intent to balance the interests of all parties involved in the dispute.

Congress intended that a violation of the section 8(g) notice requirements is an "unfair labor practice" in itself, allowing

in clause (B) of the last sentence of section 8(d) of this Act. The notice shall state the date and time that such action will commence. The notice, once given, may be extended by the written agreement of both parties.

25. In order to fully comply with § 8(g), the General Counsel outlined the procedural requirements as follows:

- (a) the 8(g) notice should be served on someone who has been designated to receive the notice or through whom the institution will actually be notified; (b) the notice should be personally delivered or sent by mail or by telegram; (c) the ten-day period begins upon receipt of the notice by the employer and FMCS; (d) the notice should specify the dates and times of both strike and picket conduct, if both are contemplated; and (e) the notice should also indicate which unit(s) will be involved in the planned action.

GENERAL COUNSEL MEMORANDUM, *supra* note 13, at 5-6.

26. S. REP. NO. 93-766, 93d Cong., 2d Sess. 4 (1974); H. REP. NO. 93-1051, 93d Cong., 2d Sess. 5 (1974).

the NLRB to grant appropriate relief to a complainant.²⁷ As a result, the NLRB has found a breach of the notice requirements without more to constitute an unfair labor practice.

Congress also made clear that injunctive relief under section 10(j) of the Act is appropriate to restrain a union from failing to give proper notice.²⁸ However, it is not clear whether a mere threat to strike or picket without compliance with the section 8(g) notice requirement also calls for a 10(j) restraining order until the question of the existence of a violation has been heard and determined by the NLRB.²⁹ There is strong support for the issuance of the restraining order in this circumstance, but the issue has not yet been resolved by the NLRB. However, a convincing argument can also be made that injunctive relief is inappropriate. Section 10(j) requires that a complaint must be filed before a restraining order can be issued. Therefore, a mere threat of a strike should not call for injunctive relief because at that point no complaint would have been made. The question should be resolved by balancing the fundamental policies of the amendments, *i.e.*, whether the threat of economic activity that would, if carried into action, be a violation of section 8(g) would cause a sufficient disruption of health care in the facility to justify denying the labor organization its right to engage in otherwise legitimate action. This writer believes when economic activity is merely threatened section 10(j) relief would not be appropriate, first because there has been no violation of the express requirements of section 8(g) and second, because such a broad restriction of the power of the union is unnecessary. When any economic activity is merely threatened, no real injury to the public has yet resulted. Requiring the union to give notice before it even threatens action and before any injury to the public has occurred gives management a clear advantage at the expense of the union. In addition, permitting threats without notice does not put the employer at a disadvantage because injunctive relief is available as soon as the threat materializes without the requisite notice.

In drafting the amendments, Congress considered the possibility that violation of section 8(g) might also entail violations of other sections of the Act. For example, some Congressmen

27. *Id.*; see also 120 CONG. REC. 12935 (1974).

28. 120 CONG. REC. 12935-36 (1974).

29. *Id.*

voiced strong support for the idea that a section 8(g) notice violation should also constitute a refusal to bargain, an unfair practice under section 8(b)(3).³⁰ In addition, the legislative history reveals that when a labor organization sends notice to a health care institution who is a secondary employer not involved in the primary dispute, that notice will constitute a "threat" in violation of section 8(b)(4) of the Act.³¹ Furthermore, a section 8(g) notice to picket will be viewed as a "threat to picket" under section 8(b)(7).

The House and Senate Reports raise the question of whether service of repeated notices upon a health care institution without any ensuing activity constitutes a section 8(b)(3) refusal to bargain. The Guidelines established by the General Counsel's Office indicates that such activity does violate the Act.³² However, it must be emphasized that repeated notices of activity is only evidence supporting a section 8(b)(3) charge. Standing alone, it will not constitute a violation. The General Counsel's position is based on the need to maintain health care throughout a dispute. However, this reasoning is fallacious because repeated notices would not cause a disruption greater than the actual strike or picketing which would be lawful after the notice period ends. The rights of employees cannot be totally disregarded by the desire to prevent disruption of the facility without destroying the vitality of the amendments.

A similar problem is posed by intermittent economic activity, *i.e.*, repeated notices with repeated strike or picket activity. The General Counsel Guidelines state that such activity would evidence a refusal to bargain to be considered with other factors in determining a violation.³³ However, recent decisions by the Supreme Court indicate that the General Counsel's position may not be consistent with the objectives of the Act.³⁴ According to the Court, the fact that the challenged activity is legitimate when viewed by itself at the very least diminishes its significance as a factor in the NLRB's determination.

30. 120 CONG. REC. 12935 (1974); *see also* 120 CONG. REC. 22574 (1974) for opposing views of Senator Williams.

31. 120 CONG. REC. 12935 (1974); S. REP. NO. 93-766, 93d Cong., 2d Sess. 4 (1974); H. REP. NO. 93-1051, 93d Cong., 2d Sess. 5 (1974).

32. GENERAL COUNSEL MEMORANDUM, *supra* note 13, at 6, 8.

33. *Id.* at 12.

34. *See, e.g.*, NLRB v. Insurance Agents Int'l Union, 361 U.S. 477 (1960); Lodge 76, International Machinists & Aerospace Workers v. Wisconsin Employment Relations Comm'n, 96 S. Ct. 2548 (1976).

The two most important questions faced by the NLRB concerning the section 8(g) notice provisions deal with the circumstances in which notice is required. The question of when notice is required was considered in the Committee Reports. These Reports have had a determinative effect on how the NLRB has construed the broad language of the Act. These Reports indicate that any strike or picketing activity requires ten-day notice, even though the activity does not relate to bargaining.³⁵ The legislators emphasized this point by referring to examples of when the notice would be required. The examples included recognition strikes, area standard strikes, secondary strikes, jurisdictional strikes and stranger picketing.³⁶ Accordingly, the General Counsel Guidelines require section 8(g) notice for all strike and picketing activity.³⁷

The NLRB has not been entirely consistent in its approach to when section 8(g) notice is required. In the early case of *Plumbers Local 630*,³⁸ a labor organization picketed a non-union subcontractor who was doing renovation work for a hospital on the hospital premises. The NLRB relied heavily on a strict reading of section 8(g) and the Committee Reports to find that proper notice should have been given. The NLRB rejected the union's argument that the picketing had caused no disruption in health care services: "[A]ny strike or picketing at the premises of a health care institution, even primary reserved gate picketing directed at a subcontractor, is proscribed in the absence of proper notices."³⁹ However, in a strong dissent, Members Fanning and Jenkins took a broader view of the statutory language and the legislative intent. In proving a section 8(g) violation the dissent would require an affirmative showing of disruption in the health care facility caused by the union activity. If the union could show that it had successfully separated its activity from the operation of the hospital, no requirement of a section 8(g) notice would exist.⁴⁰

In the subsequent case of *First Health Care Corp.*,⁴¹ the

35. 120 CONG. REC. 16899-900 (1974).

36. 120 CONG. REC. 12935 (1974); see also 120 CONG. REC. 12939 (1974) for comments by Senator Javits. For the Board's reflection of this argument, see *First Healthcare Corp.*, 222 N.L.R.B. No. 15, 91 LRRM 1097 (Jan. 14, 1976).

37. GENERAL COUNSEL MEMORANDUM, *supra* note 13, at 12.

38. 219 N.L.R.B. 846 (1975).

39. *Id.* at 840.

40. *Id.* at 841.

41. 222 N.L.R.B. No. 15, 91 LRRM 1097 (Jan. 14, 1976).

NLRB faced a sympathy strike situation. The union representing the hospital's employees had given the requisite ten-day notice and was picketing the hospital. At this time, leaders of a second union which represented no employees at the hospital joined in the picketing for a period of several hours. The second union gave no section 8(g) notice to either the hospital or the FMCS before engaging in the picketing. The administrative law judge held that there had been no violation of the Act because the sympathy strike was a mere extension of the original picketing for which proper notice had been given and that no added economic pressures had been brought to bear on the operation of the facility by the sympathy picket.⁴² The NLRB reversed and found a violation of section 8(g) under a very literal interpretation of its terms. Although recognizing that a conflict between the policies of employee protection and public interest may in some cases occur, the NLRB ruled that there is a presumption of disruption to the health care facility when any strike or picketing takes place on hospital premises. The dissenting opinion, joined in by Chairman Murphy and Member Fanning, contended that the majority opinion defeated the spirit of the Act by applying a rigid interpretation to section 8(g).⁴³ According to the dissent, where no evidence of disruption to health care services caused by the secondary employer's activity is shown, a finding of an unfair labor practice should not be made.

The dissenting opinions of these cases have presented the more reasonable interpretation of section 8(g). By applying a strict construction of section 8(g) to situations where third-party unions become tangentially involved in disputes concerning a health care institution, the NLRB has defeated the fundamental purpose of the amendments. A rigid analysis of section 8(g) destroys the balance between employee protection and maintenance of patient care which is necessary for an equitable resolution of disputes in the health care industry. In its concern for maintaining health care, the Board has defeated the rights of the employees to engage in economic activities which in fact pose no threat to health services at all. By tipping the balance so greatly in favor of maintaining patient care, the NLRB has actually created a shelter for employers in deroga-

42. *Id.*, at ____, 91 LRRM at 1097.

43. *Id.* at ____, 91 LRRM at 1098-99.

tion of the interests of the other parties involved.

The legislative history of the amendments reveals that there are two situations when section 8(g) notice is excused. A labor organization may engage in strike or picketing activity without first giving the advance ten-day notice or may begin the activity after notice was given but before the ten days has run, first, when the disruption is intended to protest a serious unfair labor practice by the employer. This exemption conforms with both the decision of the Supreme Court in *Mastro Plastics Corp. v. NLRB*⁴⁴ and the legislative history⁴⁵ of the amendments. Accordingly, the General Counsel's Office has recognized this exemption and has not issued a section 8(g) charge when a union was picketing in protest of the employer's "serious" and "flagrant" unfair labor practices.⁴⁶ However, the General Counsel Memorandum states that "[s]ec. 8(g) notice requirements must be complied with before a strike or picketing to protest 'lesser' unfair labor practices. . . ."⁴⁷ The distinction between a "serious" and "lesser" unfair labor practice is obviously one of fact to be determined on a case-by-case basis.

The second instance when the requirements of section 8(g) are excused is when a labor organization which has already given notice has breached the ten-day waiting period because during that time the employer engaged in activities that would "undermine the bargaining relationship that would otherwise exist."⁴⁸ This exemption insures that the bargaining parties are left in the same economic position after notice is given as they were in before the ten-day waiting period began.

Just as the employees cannot breach the notice requirement, neither can the employer take an unfair advantage of it. For example, the Committee Reports show that the employer may not stockpile supplies in contemplation of a long strike, and may not bring in large numbers of new personnel⁴⁹ without releasing the labor organization from their section 8(g) obliga-

44. 350 U.S. 270 (1956).

45. 120 CONG. REC. 12935-36 (1974); 120 CONG. REC. 16900 (1974).

46. N.L.R.B. GENERAL COUNSEL'S MONTHLY REPORT ON HEALTH CARE INSTITUTION CASES § III, at 6 (Jan. 24, 1975).

47. GENERAL COUNSEL MEMORANDUM, *supra* note 13, at 14.

48. 120 CONG. REC. 12935 (1974).

49. See, e.g., S. REP. NO. 93-766, 93d Cong., 2d Sess. 4-5 (1974); H. REP. NO. 93-1051, 93d Cong. 2d Sess. 6 (1974).

tion and permitting them to strike or picket immediately. While the employer may lawfully act to maintain health care services, especially the critical life sustaining services, during strike activity, he may not try to establish an economic advantage over the labor organization during the notice period which would alter the parties' relative bargaining positions.

One obvious difficulty that the labor organization faces in deciding whether the employer has "undermined the bargaining relationship," is a lack of access to proof. If the union's suspicions are unfounded, it risks an unfair labor practice charge for violating section 8(g). On the other hand, if it waits the full ten days, the union may jeopardize its most effective bargaining position. However, this dilemma, though unfortunate, is justified in order to protect the facility's patients. Under the circumstances, it is certainly not too great a price to pay.⁵⁰

Absent any notice violations by either side and after the strike or picketing has begun, both the employer and labor group may engage in any tactics which do not violate the Act. At this point the employer can hire replacements and engage in other activities necessary in order to preserve his business. The ally doctrine may operate to enlarge the scope of the dispute.⁵¹ Under the struck work aspect⁵² of the ally doctrine, a secondary employer who agrees to accept work from the primary employer which he would not have done but for the strike enmeshes himself in the dispute and loses his status as a neutral party. Once his neutral status is lost, the labor organization may direct its economic activity at this secondary employer as well, whether the secondary employer is another health care institution or not. However, the legislative history of the amendments reveals that a secondary employer may perform certain services for the primary employer without becoming his ally. When a secondary employer provides either equipment or personnel necessary to maintain the life sustaining services of the primary employer or accepts critically ill patients from the primary institution, it does not lose its neu-

50. The employer does have a general duty to provide information which is necessary and relevant to enable the union to intelligently perform its representative functions. But under these circumstances such a procedure often works too slowly to resolve the immediate problems. See *NLRB v. Truitt Mfg. Co.*, 351 U.S. 149 (1956).

51. See C. MORRIS, *THE DEVELOPING LABOR LAW* ch. 23(E), at 635 (1971).

52. *Id.* at 636.

tral status.⁵³ In addition, patients are also free to leave the primary facility of their own will and seek care at another institution. But, Senator Williams made it clear that where another employer accepts routine patient care from the primary employer, he provides support for the primary employer's bargaining position and acts at his own peril.⁵⁴

Section 8(g) applies only to labor organizations. Presumably, individual employees need not comply with the notice requirements before engaging in a strike or picketing activity. This interpretation is supported by the General Counsel Memorandum. However, that memorandum also points out that individual activity is not protected by the Act and may subject the employee to discharge.⁵⁵ The memorandum implies that employers are not obligated to give the labor organization a section 8(g) notice before exerting their economic force. Thus, the employer can lock out his employees without violating section 8(g),⁵⁶ although, of course, he is not thereby excused from complying with other relevant sections of the Act.⁵⁷

VI. AMENDMENTS TO SECTION 8(d) NOTICE REQUIREMENTS

Section 8(d) establishes the mutual obligation of employers and representatives of the employees to bargain collectively and sets up the procedural framework defining the obligations of each party. The first addition to section 8(d) enforces the notice provisions of section 8(g) by providing that any employee "who engages in any strike within the appropriate period specified in subsection (g) of this section shall lose his status as an employee of the employer engaged in the particular labor dispute." An early interpretation of this section involved hospital employees who breached the section 8(g) notice provisions by engaging in informational picketing before the ten days had run.⁵⁸ The employer discharged four of the union members involved in the picketing. The General Counsel found that the employees had not violated section 8(g) because the

53. 120 CONG. REC. 12935 (1974).

54. 120 CONG. REC. 22575 (1974).

55. GENERAL COUNSEL MEMORANDUM, *supra* note 13, at 17.

56. For an indication on how the legislature dealt with this issue see *Hearings on S. 794 and S. 2292 Before the Subcomm. on Labor of the Senate Comm. on Labor and Public Welfare*, 93d Cong., 1st Sess. 436 (1973).

57. See, e.g., § 8(d)(A) and § 213(c) of the Act.

58. N.L.R.B. GENERAL COUNSEL'S MONTHLY REPORT ON HEALTH CARE INSTITUTION CASES § III, at 6 (Jan. 24, 1975).

picketing activity was in protest over certain flagrant unfair labor practices committed by the employer. The opinion narrowly interpreted section 8(d) to require that employee status is sacrificed only when the employee engages in a strike in violation of section 8(g).⁵⁹ Therefore, mere picketing as occurred in this case does not justify discharge under section 8(d). This interpretation explicitly reversed an earlier position taken by the General Counsel's Office concerning the language of section 8(d).⁶⁰

The other amendments to section 8(d)⁶¹ relate to the procedural requirements for resolving collective bargaining contract disputes. Section 8(d)(A) alters the notice requirements contained in section 8(d)(1), (3) and (4) when a health care institution is a party to the dispute. The Act now requires written notice to the other party ninety days prior to the proposed termination or modification of an existing contract. In contrast, section 8(d)(1) requires only a sixty-day notice when a health care institution is not involved. When a health care institution is involved, written notice must also be given to the FMCS and other appropriate state or territorial agencies sixty days before termination or modification of the existing contract. Section 8(d)(3) requires only a thirty-day notice where a health care institution is not involved. Finally, section 8(d)(A) requires that the existing contract continue in full force, preserving the rights of both parties for ninety days after the initial notice to the other party or until the date of expiration of the existing contract, whichever occurs later. Where a health care institution is not the employer, section 8(d)(4) requires only a sixty-day extension of the contract where a health care institu-

59. *Id.* at 8; *see also Id.* at 4.

60. GENERAL COUNSEL MEMORANDUM, *supra* note 13, at § IV.

61. The amended procedural requirements of § 8(d) read:

(A) The notice of section 8(d)(1) shall be ninety days; the notice of section 8(d)(3) shall be sixty days; and the contract period of section 8(d)(4) shall be ninety days.

(B) Where the bargaining is for an initial agreement following certification or recognition, at least thirty days' notice of the existence of a dispute shall be given by the labor organization to the agencies set forth in section 8(d)(3).

(C) After notice is given to the Federal Mediation and Conciliation Service under either clause (A) or (B) of this sentence, the Service shall promptly communicate with the parties and use its best efforts, by mediation and conciliation, to bring them to agreement. The parties shall participate fully and promptly in such meetings as may be undertaken by the Service for the purpose of aiding in a settlement of the dispute.

tion is not involved.

Section 8(d)(B) adds another notice provision dealing with bargaining disputes about an initial agreement as opposed to the termination or modification of an existing contract. The new section requires a thirty-day written notice to the FMCS and to any government arbitration agency of the existence of a dispute concerning an initial agreement. This section emphasizes the concern which the legislators had for the initial impact of these amendments on the health care industry.

It is as yet unsettled how the timing of the section 8(g) notice relates to the section 8(d) notices. Section 8(g) specifically provides that "in the case of bargaining for an initial agreement following certification or recognition the notice required by this subsection shall not be given until the expiration of the period specified" in section 8(d)(B). However, the absence of similar language in provisions governing disputes over the termination or modification of an existing contract implies a different result in these situations. In a termination or modification case, the contract itself would determine when the service of a section 8(g) notice is appropriate, since the contract determines the duration of the present obligations of the parties. Therefore, because the labor organization could engage in a strike or picketing when the agreement expires, it could serve the section 8(g) notice either ten days prior to the termination of the contract or ten days prior to the ninety-day extension provided for in section 8(d)(A). The labor organization need not wait until the section 8(d)(A) notice period has run before giving section 8(g) notice and can thus extend the initial ninety-day period by an extra ten days.⁶²

Section 8(d)(C) applies to the health care industry alone and requires mandatory mediation by the FMCS of disputes. The new section specifies that the parties "shall participate fully and promptly"⁶³ with the FMCS in order to settle the dispute. This amendment specifically reflects congressional concern for maintaining health care services throughout disputes in this industry, especially when read in light of section 204(a)(3),⁶⁴ which also requires the participation of the FMCS

62. S. REP. NO. 93-766, 93d Cong., 2d Sess. 5 (1974).

63. 29 U.S.C. § 158(d)(C).

64. Sec. 204(a)(3) of the Act reads:

(3) in case such dispute is not settled by conference, participate fully and

in settling disputes. The General Counsel Memorandum indicates that a refusal to participate with the FMCS might constitute a refusal to bargain in violation of section 8(a)(5) or section 8(b)(3),⁶⁵ regardless of the NLRB decision in *Midas International Corp.*,⁶⁶ where the NLRB held that refusal to participate in mediation was not a per se refusal to bargain.

The amendments also contain a new section 213,⁶⁷ authorizing the Director of the FMCS to establish an impartial board of inquiry to investigate the unresolved issues in a dispute if he

promptly in such meetings as may be undertaken by the Service under this Act for the purpose of aiding in a settlement of the dispute.

65. GENERAL COUNSEL MEMORANDUM, *supra* note 13, at 21-22.

66. 150 N.L.R.B. 486 (1964).

67. Sec. 213 reads:

(a) If, in the opinion of the Director of the Federal Mediation and Conciliation Service a threatened or actual strike or lockout affecting a health care institution will, if permitted to occur or to continue, substantially interrupt the delivery of health care in the locality concerned, the Director may further assist in the resolution of the impasse by establishing within 30 days after the notice to the Federal Mediation and Conciliation Service under clause (A) of the last sentence of section 8(d) (which is required by clause (3) of such section 8(d)), or within 10 days after the notice under clause (B), an impartial Board of Inquiry to investigate the issues involved in the dispute and to make a written report thereon to the parties within fifteen (15) days after the establishment of such a Board. The written report shall contain the findings of fact together with the Board's recommendations for settling the dispute, with the objective of achieving a prompt, peaceful and just settlement of the dispute. Each such Board shall be composed of such number of individuals as the Director may deem desirable. No member appointed under this section shall have any interest or involvement in the health care institutions or the employee organizations involved in the dispute.

(b)(1) Members of any board established under this section who are otherwise employed by the Federal Government shall serve without compensation but shall be reimbursed for travel, subsistence, and other necessary expenses incurred by them in carrying out its duties under this section.

(2) Members of any board established under this section who are not subject to paragraph (1) shall receive compensation at a rate prescribed by the Director but not to exceed the daily rate prescribed for GS-18 of the General Schedule under section 5332 of title 5, United States Code, including travel for each day they are engaged in the performance of their duties under this section and shall be entitled to reimbursement for travel, subsistence, and other necessary expenses incurred by them in carrying out their duties under this section.

(c) After the establishment of a board under subsection (a) of this section and for 15 days after any such board has issued its report, no change in the status quo in effect prior to the expiration of the contract in the case of negotiations for a contract renewal, or in effect prior to the time of the impasse in the case of an initial bargaining negotiation, except by agreement, shall be made by the parties to the controversy.

(d) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

feels that the dispute will "substantially interrupt" health care services at the locality concerned. When the dispute is related to the termination or modification of an existing contract, the board must be established within thirty days after the initial ninety-day notice required to be sent to the FMCS under section 8(b)(A). If the dispute concerns bargaining for an initial agreement, the board must be established within ten days after the thirty-day notice required by section 8(d)(B). The report and recommendations of the board of inquiry must be submitted within fifteen days after the assignment was made. This section must be read in conjunction with section 8(d), both because the timing and procedure of section 213 depend upon the notice provisions of sections 8(d)(A) and (B) and, more importantly, because section 213 derives its significance to a great extent from the mandatory mediation provision of section 8(d)(C).

Section 213(c) provides that for a period of fifteen days after the board report has been submitted, "no change in the status quo" shall be made by either party, except, of course, by agreement. The "status quo" which must be preserved is defined as that condition which existed prior to the expiration of the contract in a contract renewal case, or prior to impasse in the case of initial bargaining. This "status quo" provision will not have any substantial effect on contract termination or modification cases because it does not alter the ninety-day contract extension requirement found in section 8(d)(A). However, depending on how early in the ninety-day section 8(d) notice period a board of inquiry is established, the "status quo" provision of section 213(c) could extend the thirty-day notice requirement of section 8(d)(B) to forty days where employee or employer activity would be proscribed. But, in fact, this extension would not diminish their right to strike, since presumably the labor organization could still give their section 8(g) notice at the end of the initial thirty days and strike at the moment that the forty days ran. The same result would have occurred without the extension provided by section 213(c). The major restriction imposed by section 213 is placed on the employer, not the employees. An employer may not engage in any economic warfare during these additional ten days. For example, he is prohibited from locking out his employees during the "status quo" period. But if no board of inquiry had been established, no such restriction on the employer's tactics is required by section 8(g).

Because the amendments to section 8(d) and section 213 deal predominantly with procedures which enable the FMCS to become involved in contract negotiation disputes before they ripen into disruptive strikes or lockouts, it is difficult to gauge the effect they have had on the health care industry. However, initial reports indicate that the FMCS has had substantial success in resolving labor disputes in health care facilities, and it can only be presumed that at least part of this success can be attributed to the new procedures outlined in the amendments. In the first eleven months of the operation of the amendments the FMCS recorded 1400 cases involving health care facilities. Of these cases, only 37 resulted in work stoppages.⁶⁸ Furthermore, by implementing the new powers contained in section 213, the Director of the FMCS appointed a board of inquiry in 54 cases, of which only four resulted in work stoppages.⁶⁹ Future reports should provide an even clearer indication of the success of the new procedures because the FMCS health care case load has increased dramatically since the enactment of the amendments.⁷⁰

The major problems which still confront the FMCS in mediating health care industry disputes relate not to the procedures adopted in the Act, but to secondary issues. For example, health care management has not yet acquired bargainers with sufficient experience to conduct negotiations smoothly.⁷¹ Second, as the FMCS report notes, "third party rate regulators" such as insurance companies and government sponsored care programs play an important "behind the scenes" role in determining final wage and hour settlements.⁷² Because a nonprofit health care institution depends upon independent sources for financing, the FMCS must consult with insurance companies and government agencies before settlement proposals can be submitted to the disputing parties. In these circumstances, the board of inquiry may be an important means of clarifying the issues for more fruitful negotiations.

The FMCS has just begun to establish a formula for determining when it is appropriate to appoint a board of inquiry.

68. FEDERAL MEDIATION AND CONCILIATION SERVICE, 28TH ANNUAL REPORT (FISCAL YEAR 1975), ch. IV, at 25.

69. *Id.*

70. *Id.* at 26.

71. *Id.* at 27.

72. *Id.*

Certainly, section 213 makes it clear that this decision is within the discretion of the Director of the FMCS and must therefore be made on a case-by-case basis. Nevertheless, despite the statistical success of the boards of inquiry used so far, they have been appointed only in a few cases.⁷³ The FMCS has based the decision on several criteria, the most important of which is the potential disruption to health care services in the locality concerned:

Given the special services supplied by the hospitals involved, the hardship and confusion that would result if a walkout forced transfer of patients to other already crowded hospitals in the area and considering that private physicians would be called in from their own practices to assist in struck hospitals, it was decided that a Board should be appointed.⁷⁴

In another case, the FMCS refused to appoint a board because large numbers of open hospital beds at other facilities reduced the risk of serious disruption to community health services.⁷⁵ It appears that the Director of the FMCS first looks to the respective negotiating positions of the parties to determine whether a settlement is likely. If not, he will consider such factors as expenses, the possibility of delay in present negotiations, the availability of board members able to aid in settling the particular dispute, whether the parties are ready to listen to the board report, and finally and most importantly, the potential for disruption of health care services within the community.

In summing up how the procedural changes to section 8(d) and section 213 have worked to date, the FMCS has commented: "The amendment has improved stability in health care bargaining, established a uniform structure of bargaining . . . for both proprietary and private nonprofit hospitals and created safeguards for patient care in the event of a work stoppage."⁷⁶ If this is a true analysis, the legislative purpose of the amendments has already been fulfilled.

VII. RELIGIOUS EXEMPTION

Section 19⁷⁷ provides that any employee of a health care

73. *Id.* at 25.

74. *Id.* at 28-29.

75. *Id.* at 29.

76. *Id.* at 27.

77. Sec. 19 reads:

institution who is a member of a bona fide religion which has traditionally held conscientious objections to labor organizations will not be required to "join or financially support any labor organizations as a condition of employment." Congress recognized the "special humanitarian character of health care institutions"⁷⁸ and felt that closed shops might create problems concerning dues collections, particularly at facilities with close religious affiliations. However, the amendment also applies to persons who might attempt to use the exemption for the purpose of receiving a "free ride."⁷⁹ Accordingly, section 19 provides that employees exempt from supporting a labor organization may be required to pay sums of money equal to initiation and dues fees to a tax exempt nonreligious charitable fund in lieu of making payments to the labor organization.

The NLRB has viewed section 19 as only a limited exception to union security obligations. The burden of proving membership in a bona fide religion which has traditionally objected to labor organizations is placed on the individual. The legislative history supports this narrow construction of the section 19 exemption. It illustrates Congress' desire that section 19 should not become a loophole for individuals seeking to avoid dues payments.⁸⁰ In an early case decided by the General Counsel's Office, a woman claimed the section 19 exemption, based on her private religious beliefs.⁸¹ Her claim was based on her idiosyncratic interpretation of the tenets of Roman Catholicism, her religion. However, she did not show that Roman Catholicism historically objected to labor organizations. The General

Any employee of a health care institution who is a member of and adheres to established and traditional tenets or teachings of a bona fide religion, body, or sect which has historically held conscientious objections to joining or financially supporting labor organizations shall not be required to join or financially support any labor organization as a condition of employment; except that such employee may be required, in lieu of periodic dues and initiation fees, to pay sums equal to such dues and initiation fees to a nonreligious charitable fund exempt from taxation under section 501(c)(3) of the Internal Revenue Code, chosen by such employee from a list of at least three such funds, designated in a contract between such institution and a labor organization, or if the contract fails to designate such funds, then to any such fund chosen by the employee.

78. S. REP. NO. 93-766, 93d Cong., 2d Sess. 4 (1974).

79. For comments made during congressional debate see 120 CONG. REC. 22574 (1974); 120 CONG. REC. 16902-03 (1974); 120 CONG. REC. 13539-40 (1974).

80. 120 CONG. REC. 22574 (1974); 120 CONG. REC. 16902-03; 120 CONG. REC. 13539-40 (1974).

81. N.L.R.B. GENERAL COUNSEL'S MONTHLY REPORT ON HEALTH CARE INSTITUTION CASES § III, at 10.

Counsel's Office rejected the woman's claim on the ground that a restrictive construction of section 19 was intended by Congress.⁸² Thus, it appears that the Board will take a narrow approach to section 19 claims by remaining sensitive to an employee's well-founded religious convictions, without losing sight of potential "free rider" problems.

In some situations, the section 19 exemption question is overshadowed by other issues. For example, where members of a religious order are employed at a health care institution owned and operated by their order, the applicability of the section 19 exemption may never be reached because the members of the order may be excluded from the labor organization as inappropriate for any bargaining unit.

VIII. RECOGNITIONAL AND ORGANIZATIONAL PICKETING

Section 8(b)(7)(C)⁸³ provides that a labor organization may picket the premises of an employer for a "reasonable period of time not to exceed 30 days" where the purpose of the picketing is recognitional or organizational. However, Congress was aware of the disruptive impact such activity may have on health care institutions and indicated that section 8(b)(7) rights may be altered where a union is seeking to organize a

82. *Id.* at 11.

83. Sec. 8(b)(7)(C) reads:

(b) It shall be an unfair labor practice for a labor organization or its agents—

(7) to picket or cause to be picketed, or threaten to picket or cause to be picketed, any employer where an object thereof is forcing or requiring an employer to recognize or bargain with a labor organization as the representative of his employees, or forcing or requiring the employees of an employer to accept or select such labor organization as their collective bargaining representative, unless such labor organization is currently certified as the representative of such employees:

(C) where such picketing has been conducted without a petition under section 9(c) being filed within a reasonable period of time not to exceed thirty days from the commencement of such picketing: Provided, That when such a petition has been filed the Board shall forthwith, without regard to the provisions of section 9(c)(1) or the absence of a showing of a substantial interest on the part of the labor organization, direct an election in such unit as the Board finds to be appropriate and shall certify the results thereof: Provided further, That nothing in this subparagraph (C) shall be construed to prohibit any picketing or other publicity for the purpose of truthfully advising the public (including consumers) that an employer does not employ members of, or have a contract with, a labor organization, unless an effect of such picketing is to induce any individual employed by any other person in the course of his employment, not to pick up, deliver or transport any goods or not to perform any services.

health care facility. In cases of organizational picketing at a health care institution, a period of time less than thirty days is reasonable, although such activity need not be banned completely.⁸⁴ This result is similar to other cases where special circumstances such as violence have led the NLRB to shorten the "reasonable time" element of section 8(b)(7)(C) to less than thirty days.⁸⁵

The General Counsel's Office suggests the following guidelines for determining a reasonable time:

In evaluating the "reasonable time" period, relevant factors would include the nature of the illnesses being treated at the picketed institution and the effects of the picketing on the institution's ability to treat its patients. Where the picketing causes serious effects upon the institution's ability to treat seriously ill patients, a relatively shorter period of time should be considered "reasonable."⁸⁶

Thus, the NLRB will not automatically reduce the thirty-day period in all cases involving health care institutions, but it will be receptive to a reduction once it is shown that patient care has been affected. If Congress had intended a *per se* reduction of the "reasonable time" requirement for organizational picketing found in section 8(b)(7)(C), it could have specified a time period in the new amendments. However, since no such change was made, the NLRB is correct in its position that the right to picket granted under the Act must be preserved to the greatest extent possible.

IX. SOLICITATION AND DISTRIBUTION RULES OF HEALTH CARE INSTITUTIONS

As a general rule, broad no-solicitation rules which are not limited to working hours or to working areas of the employer's premises are presumptively invalid. However, where the employer can show that the union solicitation would interfere with production, plant discipline, or plant cleanliness,⁸⁷ this presumption is overcome. The amendments raise the question of

84. 120 CONG. REC. 12935, 12944 (1974); 120 CONG. REC. 22576 (1974).

85. See, e.g., *Local 346, International Leather Goods Union v. Compton*, 292 F.2d 313 (1st Cir. 1961); *UMW District 12*, 177 N.L.R.B. 213 (1969).

86. GENERAL COUNSEL MEMORANDUM *supra* note 13, at 29.

87. See, e.g., *Republic Aviation Corp. v. NLRB*, 324 U.S. 793 (1945); *United Steelworkers v. NLRB*, 243 F.2d 593 (D.C. Cir., 1956), *rev'd on other grounds*, 357 U.S. 357 (1958).

whether the nature of health care institutions of itself is a special circumstance justifying a broad no-solicitation/no-distribution rule at patient care facilities.

NLRB cases dealing with nursing homes decided prior to the enactment of the health care amendments show a concern for preventing disruption of patient care. These cases support the view that no-solicitation rules in health care facilities should be broader than rules in non-health care related facilities, simply because of the special nature of the work performed.⁸⁸ However, these cases limited the prohibitions against solicitation to areas of the facility actually used for patient care. Thus, in the case of *Cedar Corp.*⁸⁹ the NLRB held that a rule prohibiting distribution on a public sidewalk in front of the facility's premises was overly broad because the employer failed to show that such activity would interfere with patient care.

The NLRB continues to apply these pre-amendment standards to all nonprofit health care institutions now covered by the Act. Thus, in the case of *St. John's Hospital*,⁹⁰ the NLRB indicated that no-solicitation/no-distribution rules may extend to areas where immediate patient care is taking place, but that rules prohibiting solicitation and distribution in all areas which are merely accessible to patients and visitors is overly broad. In effect, the Board has extended the special circumstances exception to areas of direct patient care, but has retained the presumption of invalidity when applied to areas not exclusively devoted to patient care.

X. BARGAINING UNITS

During the first few years since the enactment of the amendments, while the health care industry was first being organized under the rules of the Act, the most frequently litigated issue was the scope of the bargaining unit. As a result, a well-developed standard for defining the appropriate bargaining unit now exists.

The Committee Reports reflect a strong intent to avoid a proliferation of bargaining units within a single health care

88. See *NLRB v. Summit Nursing Convalescent Home*, 472 F.2d 1380 (6th Cir. 1973); for an excellent discussion of the case see Feheley, *Amendments to the National Labor Relations Act: Health Care Institutions*, 36 OHIO ST. L.J. 235, 293-94 (1975).

89. *Cedar Corp.*, 203 N.L.R.B. 100 (1973).

90. 222 N.L.R.B. No. 182, 91 LRRM 1333 (Feb. 27, 1976).

facility.⁹¹ These Reports express the fear that a multitude of separate units might create instability in patient care because the employer would be subjected to potential labor disputes from many different fronts at almost any time. However, the NLRB has not demanded large units as an ironclad rule. Instead, the NLRB has attempted to deal realistically with the great variety of job classifications within the health care industry.

When making a unit determination in a health care institution, the NLRB relies on the traditional criteria for defining a unit with but one additional criterion specific to this industry. The criteria used are (a) mutuality of interest in wages, benefits and working conditions, (b) commonality of skills and supervision, (c) frequency of contact with other employees, (d) interchange and functional integration, (e) area practice and patterns of bargaining, and (f) congressional intent to avoid a proliferation of bargaining units within the health care industry.⁹² By employing these criteria, the NLRB has expanded the administrative construction of the concept "community of interest" and has thereby restricted the number of labeled units appropriate for the health care industry in general.

The NLRB has determined that a separate clerical unit is appropriate.⁹³ The interests of the employees in this group can be distinguished from those of other employees because they perform only administrative functions. All of their work is done within administrative offices and separated from the areas designated for patient care. Clerical employees never come in contact with patients during the ordinary course of their job. Examples of job classifications included in this unit are secretaries and office clerks. The NLRB, however, has excluded mail clerks, messengers and administrative clerks from the clerical unit, even though the majority of their time is spent in the administrative offices and their duties include only minimal

91. 120 CONG. REC. 12935 (1974); 120 CONG. REC. 22574 (1974). The legislative history goes on to say that only four units would be appropriate within a health care institution, indicating that the Board should keep it at that level. The four units listed were (a) professional, (b) technical, (c) clerical and (d) service and maintenance. 120 CONG. REC. 12943 (1974).

92. See *Riverside Methodist Hosp.*, 223 N.L.R.B. No. 158, 92 LRRM 1033 (Apr. 28, 1976); *Jewish Hosp.*, 223 N.L.R.B. No. 91, 91 LRRM 1499 (Apr. 2, 1976).

93. See, e.g., *Mercy Hosp.*, 217 N.L.R.B. No. 131 (1975); *Sisters of St. Joseph*, 217 N.L.R.B. 135 (1975).

patient contact.⁹⁴ Apparently the critical element in determining what employees should be included in this unit is patient contact. An employee whose normal duties include the slightest direct patient contact will be excluded from this unit.

The service and maintenance unit is distinguished from other units because these employees perform their duties in areas where patient care takes place. These employees need not actually care for patients, but rather maintain the physical operation of the facility, perform administrative duties within the patient care areas and render direct patient care not requiring the technical or professional skills. This unit is by far the broadest interest group and includes a wide variety of job classifications.

Based upon the factors which traditionally determine appropriate bargaining units, hospital engineers are included in the service and maintenance unit. In the case of *Methodist Hospital*⁹⁵ the NLRB found that even plant maintenance employees who are trained in specialized areas of maintenance work, such as electricians, plumbers and painters, and who use sophisticated tools of their trade, do not have a community of interest sufficiently distinct from other service and maintenance employees to constitute a separate bargaining unit. In the *Riverside* case, the NLRB, citing the congressional intent of avoiding a proliferation of bargaining units, emphasized factors such as employee contact, common facilities, and related benefits and working conditions to substantiate a similar holding.⁹⁶

Other employees found to be appropriate for the service and maintenance unit include mail clerks, messengers and purchasing department clerks.⁹⁷ Although these employees perform primarily an administrative function, their participation in patient care operations establishes a community of interest with the service and maintenance employees sufficient to include them in this general unit.

The NLRB has also included in this unit such job classifications as electrocardiogram technicians, electroencephlograph

94. *Jewish Hosp.*, 223 N.L.R.B. No. 91, 91 LRRM 1499 (Apr. 2, 1976).

95. 223 N.L.R.B. No. 158, 92 LRRM 1033 (Apr. 28, 1976).

96. See also *Baptist Memorial Hosp.*, 224 N.L.R.B. No. 51, 92 LRRM 1223 (May 27, 1976).

97. *Jewish Hosp.*, 223 N.L.R.B. No. 91, 91 LRRM 1499 (Apr. 2, 1976).

technicians and intravenous infusion technicians. To perform their job functions, these employees do not need a high degree of education.

A minimum of special training, and no certification, registration or licensing is all that is required.⁹⁸ These factors clearly distinguish these and similar job classifications from the more highly skilled technical and professional positions. Consistent with the legislative aim to limit the number of bargaining units, the NLRB has held that these employees do not possess a community of interest sufficiently distinct from the service and maintenance employees to justify placing them in a separate unit.

The technical unit is the third separate unit which the NLRB has found appropriate in the health care industry. In order to perform jobs in this classification, the employees must have specialized skill acquired through a high degree of formal education. However, neither special certification nor a great deal of independent judgment is required in the performance of these ordinary duties. Laboratory technicians⁹⁹ are examples of employees within the technical unit. Their job qualifications require a degree in biochemistry or chemistry. Operating room technicians who must have both a degree and certification are also members of the technical unit.

Licensed practical nurses (LPN's) are included in this unit as a general rule. LPN qualifications include both formal education and licensing, but their interests are more closely aligned to those of the technical unit than the professional unit. In certain situations, however, the NLRB has placed LPN's in a professional unit where they performed jobs requiring a greater skill than is required for an LPN performing ordinary duties. Thus, in *Children's Hospital*¹⁰⁰ the NLRB held that LPN's whose jobs involved the treatment of children were professional employees and therefore were excluded from the technical unit. The NLRB cited the specialized training required for this work as well as the higher skill necessary to qualify for the job as showing a greater community of interest with the professional employees than with the technicals.

98. See *St. Luke's Episcopal Hosp.*, 222 N.L.R.B. No. 109, 91 LRRM 1359 (Jan. 30, 1976); *Methodist Hosp.*, 223 N.L.R.B. No. 186, 92 LRRM 1198 (May 21, 1976); *Jewish Hosp.*, 223 N.L.R.B. No. 91, 91 LRRM 1499 (Apr. 2, 1976).

99. *Methodist Hosp.*, 223 N.L.R.B. No. 186, 92 LRRM 1198 (May 21, 1976).

100. 222 N.L.R.B. No. 90, 91 LRRM 1440 (Jan. 22, 1976).

The final identifiable unit which the NLRB has defined as appropriate for bargaining purposes is the professional unit. The NLRB's definition of a "professional" depends on job qualifications rather than job description. As a result, a broader community of interest is established among employees performing a great variety of medical functions requiring a high degree of skill throughout the health care institution. The professional unit is comprised of employees who are highly skilled and certified. In addition, they exercise a high degree of independent judgment in the performance of their duties.¹⁰¹ Medical technologist and registered pharmacists¹⁰² are examples of job classifications which are part of a professional unit. However, the NLRB has found it appropriate to relax these standards where, as for example, laboratory employees who met the degree requirements for medical technologist were in fact performing work done by medical technologists, but had not yet been certified.¹⁰³

The NLRB has classified registered nurses as professional employees. Therefore, as a general rule, registered nurses have been placed in the professional unit for bargaining purposes.¹⁰⁴ However, there have been exceptions to this rule. The NLRB has found a unit consisting solely of registered nurses appropriate for bargaining purposes when the traditional indicia justify such a classification. In *Morristown-Hamblen Hospital Association*¹⁰⁵ the petitioning union sought a unit of all full-time registered nurses to the exclusion of other professional employees including emergency room physicians and a registered pharmacist. The NLRB found such a separate unit appropriate:

Here, the RN's are all employed in a single department and subject to the single overall supervision of the director of nursing services. The emergency room physicians report directly to the Hospital administrator or the board of directors

101. See § 2(12) of the Act.

102. See Kaiser Foundation Health Plan, 225 N.L.R.B. No. 50, 92 LRRM 1412 (June 30, 1976); Children's Hosp., 222 N.L.R.B. No. 90, 91 LRRM 1440 (Jan. 22, 1976); Morristown-Hamblen Hosp. Ass'n, 226 N.L.R.B. No. 13, 93 LRRM 1166 (Sept. 22, 1976).

103. Children's Hosp., 222 N.L.R.B. No. 90, 91 LRRM 1440 (Jan. 22, 1976).

104. See, e.g., Family Doctor Medical Group, 226 N.L.R.B. No. 22, 93 LRRM 1193 (Sept. 23, 1976); Valley Hosp., 221 N.L.R.B. No. 210, 91 LRRM 1061 (Dec. 23, 1975) [supplementing 200 N.L.R.B. No. 216, 90 LRRM 1411].

105. 226 N.L.R.B. No. 13, 93 LRRM 1166 (Sept. 22, 1976).

and the pharmacist reports to the director of supply. The nurses have formal meetings among themselves, and there is no evidence that the doctors or the pharmacist attend these meetings. The nurses' educational prerequisites, duties and responsibilities, and pay scales differ substantially from those of the emergency room physicians and the pharmacist.¹⁰⁶

This statement emphasizes the NLRB's basic position of not hesitating to increase the number of bargaining units within a health care facility regardless of congressional intent where the petitioning labor organization can establish a sufficiently distinct community of interest within a group of employees. Ultimately, the NLRB must still rely on its own experience in the field of labor relations when making the final decision concerning appropriate units.

Normally, where a union is seeking to represent a mixed professional and nonprofessional unit, the Board orders a self-determination election pursuant to section 9(b)(1).¹⁰⁷ Thus, in *Family Doctor Medical Group*¹⁰⁸ the NLRB ordered a Sonotone-type election.¹⁰⁹ Thus, the NLRB ordered a self-determination election for all professional employees, including registered nurses, laboratory technologists and a dietician, and then specified the appropriate bargaining units based on the results of the secondary professional vote. However, the NLRB has not granted a self-determination vote in every case. Where it believes that a separate professional unit would not be appropriate, it will include the professional employees in the technical unit and refuse to allow a self-determination vote.¹¹⁰

106. *Id.* at ____, 93 LRRM at 1168.

107. Sec. 9(b)(1) of the Act reads:

The Board shall decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this Act, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof: Provided, That the Board shall not (1) decide that any unit is appropriate for such purposes if such unit includes both professional employees and employees who are not professional employees unless a majority of such professional employees vote for inclusion in such unit.

108. 226 N.L.R.B. No. 22, 93 LRRM 1193 (Sept. 23, 1976).

109. Sonotone Corp., 90 N.L.R.B. 1236 (1950).

110. *Children's Hosp.*, 222 N.L.R.B. No. 90, 91 LRRM 1440 (Jan. 22, 1976). In this case, the Board did not grant a self-determination election because the only professional employees involved were a very few medical technologists. In denying the secondary vote, the Board felt that if the professionals voted to form a separate group it would be inappropriate for voting purposes.

The NLRB has also declared that certain employees are beyond the scope of appropriate bargaining units and has denied them a vote in representation elections because they are either (a) employees whose interest in employment is not sufficient to place them in any bargaining unit, or (b) employees whose interests are too closely aligned with management to be included in a bargaining unit. Students working at a hospital only part-time and receiving wages lower than any other employee group are an example of an uninterested group excluded from representation by the NLRB.¹¹¹ These employees generally work only after school for a single school year and thus do not share a community of interest with any other employees sufficient enough to place them in one of the labeled units. Certainly they do not constitute an appropriate unit standing alone.

The exclusion of employees whose interests are closely associated with management is illustrated by the case of *St. Anthony Center*,¹¹² where the health care facility was closely affiliated with the Sisters of Charity of the Incarnate Word religious order. Several employees having job classifications falling within the unit sought by the petitioning union were also members of this religious order. Facing the issue of whether to exclude these employees from the bargaining unit, the NLRB cited the allegiance which the disputed employees owed to the employer and then went on to state:

In sum, we are satisfied that the members of the religious order here at issue should not be included in the unit sought to be represented by the Petitioner. In so doing, we rely particularly on the fact that their economic interests do not coincide with those of the lay employees; on their different terms and conditions of employment; and on the conflicts of loyalty that could result from their simultaneous membership in the bargaining unit and in the same religious order that owns and operates Saint Anthony Center. Accordingly, we shall exclude sisters of the Order from the unit.¹¹³

111. See *Pawating Hosp. Ass'n*, 222 N.L.R.B. No. 106, 91 LRRM 1230 (Jan. 30, 1976) (high school students); *Clark County Mental Health Center*, 225 N.L.R.B. No. 105, 92 LRRM 1545 (July 29, 1976) (psychology interns).

112. 220 N.L.R.B. No. 139, 90 LRRM 1405 (Oct. 1, 1975).

113. *Id.* at —, 90 LRRM at 1409; for a further discussion of this issue see *St. Rose de Lima Hosp.*, 223 N.L.R.B. No. 224, 92 LRRM 1181 (May 21, 1976).

Where a religious organization operates a health care facility in which all employees having a special contractual relationship with the employer by virtue of membership in the religious organization which operates the facility, these employees will be excluded from union representation by the NLRB. Under these circumstances, the section 19 religious exemption would never apply since the religiously affiliated employees would be excluded from union activity in the first instance.

The status of interns and residents has created the most interesting dilemma for the NLRB. In a series of recent decisions, the NLRB has attempted to define their status, but has succeeded only in creating more confusion. In the case of *Cedars-Sinai Medical Center*¹¹⁴ the NLRB held that interns and residents were not "employees" under the Act and thus were not subject to the duties and obligations placed on employees under federal law. Subsequently, in the case of *Kansas City General Hospital and Medical Center, Inc.*,¹¹⁵ the NLRB ruled that health care institutions were not "employers" under the Act for the purpose of disputes involving interns or residents. This decision indicates that state legislation could control the labor relations between employers and interns and residents. However, the NLRB recently revised its decision in *Kansas City General Hospital and Medical Center, Inc.*¹¹⁶ and held that federal law does preempt state laws in this area of labor relations and therefore presumably that in disputes involving health care institutions and residents or interns neither party is subject to any federal or state restraints. The danger to the public interest of this is pointed out by Member Fanning in his dissenting opinion: "Such disputes will be resolved solely in accordance with the militancy and economic resources of the contending parties, free of any restraining or mediatory influences of Federal or state law."¹¹⁷ Certainly a more definite statement on the law concerning the status of residents and interns must be made by the NLRB or, if necessary, by the legislature, so that this legal issue does not become even more confused and before the stability sought by the Act is lost.

114. 223 N.L.R.B. No. 57, 91 LRRM 1398 (March 19, 1976). In *Cedars-Sinai*, the Board held that interns and residents were to be considered students, and therefore they were exempt under the Act.

115. 225 N.L.R.B. No. 14, 92 LRRM 1379 (June 24, 1976).

116. 225 N.L.R.B. No. 14A.

117. *Id.*

XI. CONCLUSION

The health care amendments have had a dramatic impact on management-labor relations in the health care industry. Predictably, early cases faced by the NLRB have dealt largely with union organizing, but other broader issues have also been considered, and the NLRB has had some opportunity to refine the language of the new legislation. The NLRB has stabilized labor relations in the industry by applying the specific provisions of the amendments with a constant reference to the dual purposes of the legislation to protect labor and to maintain patient care. It has tried to strike a balance between the often competing interests of the employee, the employer and the public. As these competing interests become more acquainted with their respective duties and obligations under the new law, the issues will crystallize and the NLRB determinations will be more refined. Hopefully, as the courts decide appeals of NLRB decisions, the law will become even more clearly defined. At least thus far it can be concluded that the amendments have provided some resolutions to some of the most complex problems in labor law.

JOHN M. MILLER